

Attachment 4.19-D
Part I
Subpart C
Exhibit C-4

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS



KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

June 20, 1997

FIELD(1)

Dear Administrator:

FIELD(2)

We forwarded the per diem rate shown on the enclosed Case Mix Payment Schedule for FIELD(3) (computer print-out) to our fiscal agent, EDS-Federal. The rate is effective FIELD(4). The payment schedule and rate reflect the cost center limitations, inflation factors, owner/related party/administrator compensation per diem limitations, incentive ranges and the full case mix adjustment in the Health Care cost center.

SRS determined this rate by applying the appropriate Medicaid program policies and regulations to the cost report (Form MS 2004) data shown on the enclosed payment schedule. Desk review adjustments to the cost report are shown on the enclosed Provider Adjustment Sheet, except transfers from one line to another, which are shown in the "Reason for SRS Adjustments" column of the schedule. (All related transfers in this column have the same key number.) IF YOU HAVE QUESTIONS ABOUT ANY DESK REVIEW ADJUSTMENT, CALL THE ADULT CARE HOME PROGRAM'S AUDIT MANAGER IN SRS AUDIT SERVICES AT (913) 296-3836.

THE FACILITY'S RATE FOR NON-MEDICAID/MEDIKAN RESIDENTS MUST EQUAL OR EXCEED THE MEDICAID/MEDIKAN RATE FOR COMPARABLE CARE AND SERVICES. If the private pay rate indicated on the agency register is lower, then the Medicaid/Medikan rate, beginning with its effective date, shall be lowered to the private pay rate reflected on the registry. The effective date of the private pay rate in the registry shall be the later of the effective date of the private pay rate or the first day of the following month in which complete documentation of the private pay rate is received by the agency. SEE KANSAS ADMINISTRATIVE REGULATION (KAR) 30-10-18(b).

If you disagree with the rate in the attached payment schedule, you have the right to request a fair hearing appeal in accordance with K.A.R. 30-7-64 et seq. Your written request for such an appeal should be delivered to or otherwise mailed so that it is received by the SRS Administrative Hearings Section, 2nd Floor, 610 West Tenth, Topeka, Kansas 66612 within 30 days from the date of this letter. (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if this notice letter is mailed rather than hand delivered.) Failure to timely request or pursue such an appeal may adversely affect your rights on any related judicial review proceeding.

If you have questions regarding the Medicaid rate, other than those on desk review adjustments, write to me or call at (913) 296-0703.

Sincerely,

Bill McDaniel, Administrator
Nursing Facility Reimbursement
Adult and Medical Services Commission

BRM:ckc
Enclosures

0915972403210011
 123456789012345678901234

KANSAS MEDICAID / MEDIKAM

CASE MIX SCHEDULE
 1ST QRT 1998
 PAGE 1

***** PROVIDER INFORMATION *****

PROVIDER NO.....				
FACILITY NAME.....	BEDS AVAILABLE	PRIOR	CURRENT	%CHG
ADDRESS.....	NURSING FACILITY.....	59	59	0.0
CITY/STATE/ZIP....	NF-MENTAL HEALTH.....	0	0	0.0
ADMINISTRATOR.....	TOTAL.....	59	59	0.0
	ASSISTED LIVING BEDS...	0	0	0.0
	OTHER.....	0	0	0.0
REPORT YEAR END... 12/31/96	BED DAYS AVAILABLE.....	21,195	21,594	1.9
FISCAL YEAR END... 12/31/96	INPATIENT DAYS.....	16,005	17,030	6.4
	OCCUPANCY RATE.....	75.5	78.9	4.5
INFLATION FACTOR.. 4.876	MEDICAID DAYS.....	7,823	7,746	-1.0
CHI..... 0.93	CAL DAYS IF APPL.....	0	0	
	RES DAYS USED IN DIV...	18,016	18,355	

***** RECAP OF RESIDENT RELATED EXPENSES AND RATE CALCULATION *****

	ADMIN	PLANT OPERATING	ROOM & BOARD	HEALTH CARE	TOTAL
RES RELATED EXP.....	129,921	106,336	311,072	757,755	1,305,084
COST PER RESIDENT DAY....	7.08	5.79	16.95	41.28	71.10
INFLATION.....	0.29	0.28	0.83	2.01	3.41
PPD COST BEFORE LIMITS...	7.37	6.07	17.78	43.29	74.51
PPD COST LIMITS.....NF	10.05	5.40	19.24	45.77	80.46
ALLOWED COST.....	7.37	5.40	17.78	43.29	73.84

	NF
ALLOWED COST.....	73.84
INCENTIVE FACTOR.....	0.40
REAL AND PERSONAL PROPERTY FEE.....	5.66
24-HR NURSING ADJUSTMENT.....	0.00
MINIMUM WAGE ADJUSTMENT.....	0.00
PER RESIDENT DAY RATE EFFECTIVE.....	07/01/97 79.90
PRIVATE PAY RATE.....	09/01/95 78.50

Substitute per letter dated 10/6/97

KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-5

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PROV NUM

***** EXPENSE STATEMENT *****

DESCRIPTION	LINE NO.	REPORTED EXPENSE	PROVIDER ADJUSTMT	CURRENT YEAR SRS ADJUSTMT	RESIDENT EXPENSE	PER DAY	* PRIOR YEAR * RESIDENT EXPENSE	PER DAY	% CHG	LINE NO.	REASON FOR SRS ADJUSTMENT
ADMINISTRATION											
SALARY-ADMIN	101	19,571	0	0	19,571	1.07	27,146	1.51	-29.14	101	
SALARY-CO ADM	102	0	0	0	0	0.00	0	0.00	0.00	102	
OTHER ADM SAL	103	55,559	0	0	55,559	3.03	48,512	2.69	12.64	103	
EMP BENEFITS	104	13,580	0	0	13,580	0.74	13,716	0.76	-2.63	104	
OFC SUP & PRINT	105	9,665	0	0	9,665	0.53	6,776	0.38	39.47	105	
MGT CONSULTING	106	0	0	0	0	0.00	485	0.00	0.00	106	
OWN/REL PTY CMP	107	0	0	0	0	0.00	0	0.00	0.00	107	
CENTRAL OFC	108	0	0	0	0	0.00	0	0.00	0.00	108	
PHONE & COMMUNI	109	2,814	0	0	2,814	0.15	2,916	0.16	-6.25	109	
TRAVEL	110	2,380	0	0	2,380	0.13	1,125	0.06	116.67	110	
ADVERTISING	111	720	0	0	720	0.04	1,518	0.08	-50.00	111	
LICENSES & DUES	112	4,346	0	0	4,346	0.24	2,065	0.11	118.18	112	
LEGAL/ACCTG DP	113	6,374	0	0	6,374	0.35	7,575	0.42	-16.67	113	
INS EXCEPT LIFE	114	13,628	0	0	13,628	0.74	21,103	1.17	0.00	114	
INT EXCEPT R/E	115	0	0	0	0	0.00	0	0.00	0.00	115	
LEGAL	116	126	0	0	126	0.01	0	0.00	100.00	116	
OTHER	117	295	0	0	295	0.02	854	0.05	-60.00	117	
OTHER	118	863	0	0	863	0.05	2,354	0.13	-61.54	118	
O/A LIMIT	119	0	0	0	0	0.00	0	0.00	0.00	119	
TOTAL ADMIN	120	129,921	0	0	129,921	7.08	136,145	7.56	-6.35	120	
PLANT OPERATING											
R/E & PP TAXES	121	0	0	0	0	0.00	0	0.00	0.00	121	
SALARIES	126	31,734	0	0	31,734	1.73	38,861	2.16	-19.91	126	
EMP BENEFITS	127	4,472	0	0	4,472	0.24	5,524	0.31	-22.58	127	
OWN/REL PTY CMP	128	0	0	0	0	0.00	0	0.00	0.00	128	
UTILITIES	129	45,519	0	0	45,519	2.48	48,363	2.68	-7.46	129	
MAINT & REPAIR	130	20,880	0	0	20,880	1.14	19,311	1.07	6.54	130	
SUPPLIES	131	238	0	0	238	0.01	865	0.05	-80.00	131	
SMALL EQUIPMENT	137	3,108	0	0	3,108	0.17	1,037	0.06	183.33	137	
OTHER	138	385	0	0	385	0.02	1,198	0.07	-71.43	138	
TOTAL PLANT OP	139	106,336	0	0	106,336	5.79	115,159	6.39	-9.39	139	
ROOM & BOARD											
EMP BENEFITS	141	26,232	0	0	26,232	1.43	29,083	1.61	-11.18	141	
DIETARY-SAL	142	145,545	0	0	145,545	7.93	162,745	9.03	-12.18	142	
OWN/REL PTY CMP	143	0	0	0	0	0.00	0	0.00	0.00	143	
CONSULTANT	144	9,314	0	0	9,314	0.51	0	0.00	100.00	144	
FOOD	145	66,772	0	0	66,772	3.64	65,545	3.64	0.00	145	
SUPPLIES	146	9,462	0	0	9,462	0.52	9,644	0.54	-3.70	146	
OTHER	148	143	0	0	143	0.01	34	0.00	100.00	148	
LAUNDRY-LINEN-SAL	149	33,951	0	0	33,951	1.85	33,985	1.89	-2.12	149	
LINEN - BEDDING	150	6,096	0	0	6,096	0.33	7,028	0.39	-15.38	150	
SUPPLIES	151	5,688	0	0	5,688	0.31	3,925	0.22	40.91	151	
OTHER	153	0	0	0	0	0.00	0	0.00	0.00	153	
HOUSEKEEPING-SAL	154	6,668	0	0	6,668	0.36	7,867	0.44	-18.18	154	
SUPPLIES	155	1,201	0	0	1,201	0.07	1,495	0.08	-12.50	155	
OTHER	158	0	0	0	0	0.00	0	0.00	0.00	158	
TOTAL RM & BOARD	159	311,072	0	0	311,072	16.95	321,351	17.84	-4.99	159	

JUN 06 2001

TN# MS-97-11 Approval Date _____ Effective Date 7/1/97 Supersedes TN# MS-96-07

Substitute per letter dated 10/6/97

KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I
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Exhibit C-5
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PROV NUM

***** EXPENSE STATEMENT *****

DESCRIPTION	LINE NO.	REPORTED EXPENSE	PROVIDER ADJUSTMT	CURRENT YEAR SRS ADJUSTMT	RESIDENT EXPENSE	PER DAY	* PRIOR YEAR * RESIDENT EXPENSE	PER DAY	% CHG	LINE NO.	REASON FOR SRS ADJUSTMENT
HEALTH CARE											
NURSING-RN	161	50,044	0	0	50,044	2.73	54,184	3.01	-9.30	161	
LPN/LMHT	162a	144,522	0	0	144,522	7.87	117,134	6.50	21.08	162a	
LPN/LMHT	162b	0	0	0	0	0.00	0	0.00	0.00	162b	
OTHER NURSING	163a	359,760	0	0	359,760	19.60	342,033	18.98	3.27	163a	
OTHER NURSING	163b	0	0	0	0	0.00	0	0.00	0.00	163b	
OTHER NURSING	163c	0	0	29,698	29,698	1.62	0	0.00	0.00	163c	Note Attached
EMP BENEFITS	164	88,534	0	0	88,534	4.82	81,159	4.50	7.11	164	
OWN/REL PTY CMP	165	0	0	0	0	0.00	0	0.00	0.00	165	
CONSULTANTS	166	0	0	0	0	0.00	0	0.00	0.00	166	
PURCH SERVICES	167	0	0	0	0	0.00	0	0.00	0.00	167	
SUPPLIES	168	9,941	0	0	9,941	0.54	9,979	0.55	-1.82	168	
OTHER	170	2,787	0	0	2,787	0.15	2,787	0.15	0.00	170	
THPY/OTHER SAL	171a	29,698	0	-29,698	0	0.00	22,015	1.22	0.00	171a	Note Attached
THPY/OTHER SAL	171b	0	0	0	0	0.00	0	0.00	0.00	171b	Note Attached
THPY/OTHER SAL	171c	0	0	0	0	0.00	0	0.00	0.00	171c	Note Attached
THPY/OTHER SAL	171d	0	0	0	0	0.00	0	0.00	0.00	171d	Note Attached
THPY/OTHER SAL	171e	0	0	0	0	0.00	0	0.00	0.00	171e	Note Attached
THPY/OTHER SAL	171f	0	0	0	0	0.00	0	0.00	0.00	171f	Note Attached
OWN/REL PTY CMP	172	0	0	0	0	0.00	0	0.00	0.00	172	
PAT ACT/SOC WKR	173a	17,312	0	0	17,312	0.94	17,148	0.95	-1.05	173a	
PAT ACT/SOC WKR	173b	26,975	0	0	26,975	1.47	18,453	1.02	44.12	173b	
PAT ACT/SOC WKR	173c	21,244	0	0	21,244	1.16	20,839	1.16	0.00	173c	
PAT ACT/SOC WKR	173d	0	0	0	0	0.00	0	0.00	0.00	173d	
PAT ACT SUPPLS	174	2,325	0	0	2,325	0.13	1,865	0.10	30.00	174	
OCCUP THERAPY	175	0	0	0	0	0.00	0	0.00	0.00	175	
MED RECORDS-CON	176	0	0	0	0	0.00	425	0.02	0.00	176	
PHARM-CONSULTANTS	177	0	0	0	0	0.00	0	0.00	0.00	177	
SPEECH THERAPY	178	0	0	0	0	0.00	0	0.00	0.00	178	
PHYSICAL THERAPY	179	0	0	0	0	0.00	0	0.00	0.00	179	
CONSULTANT	180	157	0	0	157	0.01	157	0.01	0.00	180	
NURSING TRNG	181a	4,171	0	0	4,171	0.23	1,946	0.11	109.09	181a	
NURSING TRNG	181b	285	0	0	285	0.02	82	0.00	100.00	181b	
RESIDENT TRANSP	182	0	0	0	0	0.00	0	0.00	0.00	182	
OTHER	183	0	0	0	0	0.00	0	0.00	0.00	183	
OTHER	188	0	0	0	0	0.00	0	0.00	0.00	188	
TOTAL HLTH CARE	189	757,755	0	0	757,755	41.28	690,206	38.31	7.75	189	
TOTAL ALLOWABLE	190	1,305,084	0	0	1,305,084	71.10	1,262,861	70.10	1.43	190	
OWNERSHIP											
INT-R/E MORTG	191	0	0	0	0	0.00	0	0.00	0.00	191	
RENT/LEASE	192	4,058	0	0	4,058	0.22	8,715	0.48	-54.17	192	
LEASEHOLD IMPRV	193	0	0	0	0	0.00	0	0.00	0.00	193	
DEPRECIATION	194	123,779	0	0	123,779	6.74	145,250	8.06	-16.38	194	
TOTAL OWNERS	195	127,837	0	0	127,837	6.96	153,965	8.55	9.52		

REAL AND PERSONAL PROPERTY FEE COMPONENT

EFF DATE	RES DAYS	MTG INT	RENT/LEASE	AMORT	DEPR	TOTAL	PPD	PROP ALLOW	VALUE FACTOR	PROP FEE
09/01/94	17,994	3,343	0	0	86,973	90,316	5.02	5.66	0.00	5.66

JUN 06 2001

TN# MS-97-11 Approval Date Effective Date 7/1/97 Supersedes TN# MS-96-07

**INSTITUTIONAL STATE PLAN AMENDMENT
ASSURANCE AND FINDING CERTIFICATION STATEMENT**

STATE: Kansas TN # - MS-97-11

REIMBURSEMENT TYPE: Inpatient Hospital
 Nursing Facility X
 ICF/MR

PROPOSED EFFECTIVE DATE: July 01, 1997

A. State Assurances and Findings. The State assures that it has made the following findings:

1. 447.253 (b) (1) (I) - The State pays for inpatient hospital services and long term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Yes

2. With respect to inpatient hospital services --
 - a. 447.253 (b) (1) (ii) (A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. N/A

 - b. 447.253 (b) (1) (ii) (B) - If a State elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in section 1861 (v) (1) (G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861 (v) (G) of the Act. N/A

If the answer is "not applicable," please indicate:

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- c. 447.253 (b) (1) (ii) (C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality. N/A
3. With respect to nursing facility services --
- a. 447.253 (b) (1) (iii) (A) - Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates takes into account the costs of complying with the requirements of 42 CFR 483 subpart B. Yes
- b. 447.253 (b) (1) (iii) (B) - The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30 (c) to provide licensed nurses on a 24-hour basis. Yes
- c. 447.253 (b) (1) (iii) (C) - The State has established procedures under which the data and methodology used to establish payment rates are made available to the public. Yes
4. 447.253 (b) (2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:
- a. 447.272 (a) - Aggregate payments made to each group of health care facilities (hospitals, nursing facilities and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. Yes
- b. 447.272 (b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities and ICFs/MR) -- when considered separately -- will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. Yes
- If there are no State-operated facilities, please indicate "not applicable." N/A
- c. 447.272 (c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42 CFR 447.296 through 447.299. N/A

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- d. Section 1923 (g) - DSH payments to individual providers will not exceed the hospital-specific DSH limits in section 1923 (g) of the Act. N/A

B. State Assurances. The State makes the following additional assurances:

1. For hospitals --

- a. 447.253 (c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation. N/A

2. For nursing facilities and ICFs/MR --

- a. 447.253 (d) (1) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after July 18, 1984 but before October 1, 1985, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate, solely as a result of a change of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation. Yes
- b. 447.253 (d) (2) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after October 1, 1985, the State's methods and standards provide that the valuation of capital assets for purposes of determining payment rates will not increase (as measured from the date of acquisition by the seller to the date of the change of ownership) solely as a result of a change of ownership, by more than the lesser of:

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- (i) ½ of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Dodge Construction index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year; or
- (ii) ½ of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year. Yes

3. 447.253 (e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates. Yes
4. 447.253 (f) - The State requires the filing of uniform cost reports by each participating provider. Yes
5. 447.253 (g) - The State provides for periodic audits of the financial and statistical records of participating providers. Yes
6. 447.253 (h) - The State has complied with the public notice requirements of 42 CFR 447.205.

Notice published on :

June 19, 1997

If no date is shown, please explain:

7. 447.253 (I) - The State pays for inpatient hospital and long-term care services using rates determined in accordance with the methods and standards specified in the approved State plan. Yes

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C. Related Information

1. 447.255 (a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: Nursing Facility

For hospitals: Include DSH payments in the estimated average rates. You may either combine hospital and DSH payments or show DSH separately. If including DSH payments in a combined rate, please initial that DSH payments are included. N/A

Estimated average proposed payment rate as a result of this amendment: 71.94

Average payment rate in effect for the immediately preceding rate period: 67.17

Amount of change: 4.77 Percent of change: 7.1%

2. 447.255 (b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:

a. The availability of services on a statewide and geographic area basis:
There are approximately 397 licensed Nfs or Nfs-MH in the State of Kansas with at least one in every county. Of these, 392 or 99% are certified to participate in the Medicaid Program. There are 15 licensed Nfs-MH in the State of Kansas; all of them participate in the Medicaid Program. Beds are available in every area of the State and close coordination with the local and area KDOA offices and AAA's allows the agency to keep close track of vacancies.

b. The type of care furnished:
Maintain the type of care furnished, and

c. The extent of provider participation:
Maintain the extent of provider participation. The extent of

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provider participation should not be affected by this change.
Ninety-nine percent of the available providers are already
participating in this program.

- d. For hospitals -- the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs:

Not Applicable

I HEREBY CERTIFY that to the best of my knowledge and belief, the information provided is true, correct, and a complete statement prepared in accordance with applicable instructions.

Completed by Janet Schelonsky

Date 9-08-97

Title Deputy Secretary